471-000-60 Instructions for Completions of Form MC-82, "Personal Assistance Claim Form"

Use: Personal Assistance Providers use Form MC-82 to bill Nebraska Health and Human Services for provider services provided to Medicaid clients.

Note: Form MC-82 is completed by the provider and sent to the client's worker at the local office. After the provider has completed the form, the local office staff completes the "Local Office Use Only" section to authorize payment for the service. Staff shall not complete this section before the provider completes the form, and staff must verify that any amount listed on the form as paid by or due from the client is correct.

Number Prepared: One copy of the three-part Form MC-82 is prepared.

Completion: After completing items 1-11, the provider sends all three parts of Form MC-82 to the client's worker at the local office. The provider completes Form MC-82 as follows:

1. Client's name: Enter the client's name.
2. Client's case number: Enter the client's nine-digit case number and two-digit ID number.
3. Referring Physician's/RN's Name: Enter the name and license number of the medical professional who signed FORM mILTC-4D, or the client's primary physician.
4. Client's Diagnosis: Write the client's diagnosis. The client's worker has this information.
5. Date of Service: Enter the date(s) for each day or week you worked. Do not exceed one week per line. This must be in month-day-year form. Use "from-to" dates for each week (for example "from 8-1-XX to 8-7-XX").
   Note: Provider services are authorized by calendar month.
   Procedure Code: Use T1019 for provider. Add Modifier Code 22 for specialized providers.
   DX Code: This is completed in the Central Office.
   Charges: Enter the charges for the week. Multiply the number of 15-minute units by the rate to determine the charges.
   Units: Enter the number of units worked that week.
6. Total Charges: Add the charges and enter the total.
7. Amount Paid by or Due from the Client: Enter the amount the client paid or must pay for the services on this claim. The client's worker has this information.
8. Balance Due: Subtract #7 from #6 and put the amount here.
9. Date: Enter the date this form is being completed.
10. Signature of Provider: Sign your name. Be sure to read the "signature of provider" statement before you sign.
11. Provider Number: Enter your eleven-digit provider number.
12. Provider name, address, and telephone number: Complete as indicated.

Local Office: The local office staff completes the section, "Local Office Use Only," by entering the number of units authorized for this billing period and the amount paid by other sources for this claim.

Distribution: After signing and dating the claim, the local office staff sends the agency (top-gold) copy of the form to the Central Office for processing and the provider (last-white) copy to the personal assistant. The local office retains a (middle-white) copy for the client's record.

Payment Inquiries: Contact Medicaid Inquiry at 1-877-255-3092 if no payment or response is received within 30 days from the date the form is sent to the Central Office, or if there are requests for adjustments to payments. For providers located in Lincoln or outside Nebraska, call (402) 471-9128.

Retention: The worker and the provider each retain their copies of Form MC-82 for four years from date of service provision to support and document all claims.

Nebraska Department of Health and Human Services
PERSONAL ASSISTANCE CLAIM FORM

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

1. Client's Name _____

2. Client's Medicaid Number _____ I.D. # _____

3. a. Referring Physician's/RN's Name _____

b. License Number _____

4. Client's Diagnosis _____

1 UNIT = 15 MINUTES, 2 UNITS = 30 MINUTES, 3 UNITS = 45 MINUTES, 4 UNITS = 1 HOUR

5.	Date of Service From:	Date of Service To:	Place of Service	Procedure Code	Modifier	DX Code	Charges	Units
A			12					
B			12					
C			12					
D			12					
E			12					
F			12					
				6. Total Charges				
				7. Amount Paid by or Due from Client				
				8. Balance Due				

SIGNATURE OF PROVIDER: I certify that (1) the services listed on this claim were medically indicated and necessary to the health of this client and were personally rendered by me; (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess of regular fees and, that no charge, in addition to line 6, will be made; (3) the information provided on this claim is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

9. Date	10. Signature of Provider **SIGN HERE**

LOCAL OFFICE USE ONLY

Number of units authorized for billing period _____

☐ Central Office Approved

POS _____

Signature

Agency Code	Date

11. Provider Number _____ - _____

12. Provider Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number ( ) _____

☐ If New Address, (check here), - Starting Date _____

HSS Medical Payments

MC-92 Rev. 4/04 (58022)
(Previous version 10/03 should NOT be used)